COMPREHENSIVE DYSPHAGIA MANAGEMENT

INDIANA OUTREACH SERVICES

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FOUNDATIONS

- ASPIRATION
- SILENT ASPIRATION
- DYSPHAGIA
- TRIGGERS
- COUGHING
- CHOKING
- GASTROESOPHAGEAL DISEASE(GERD)

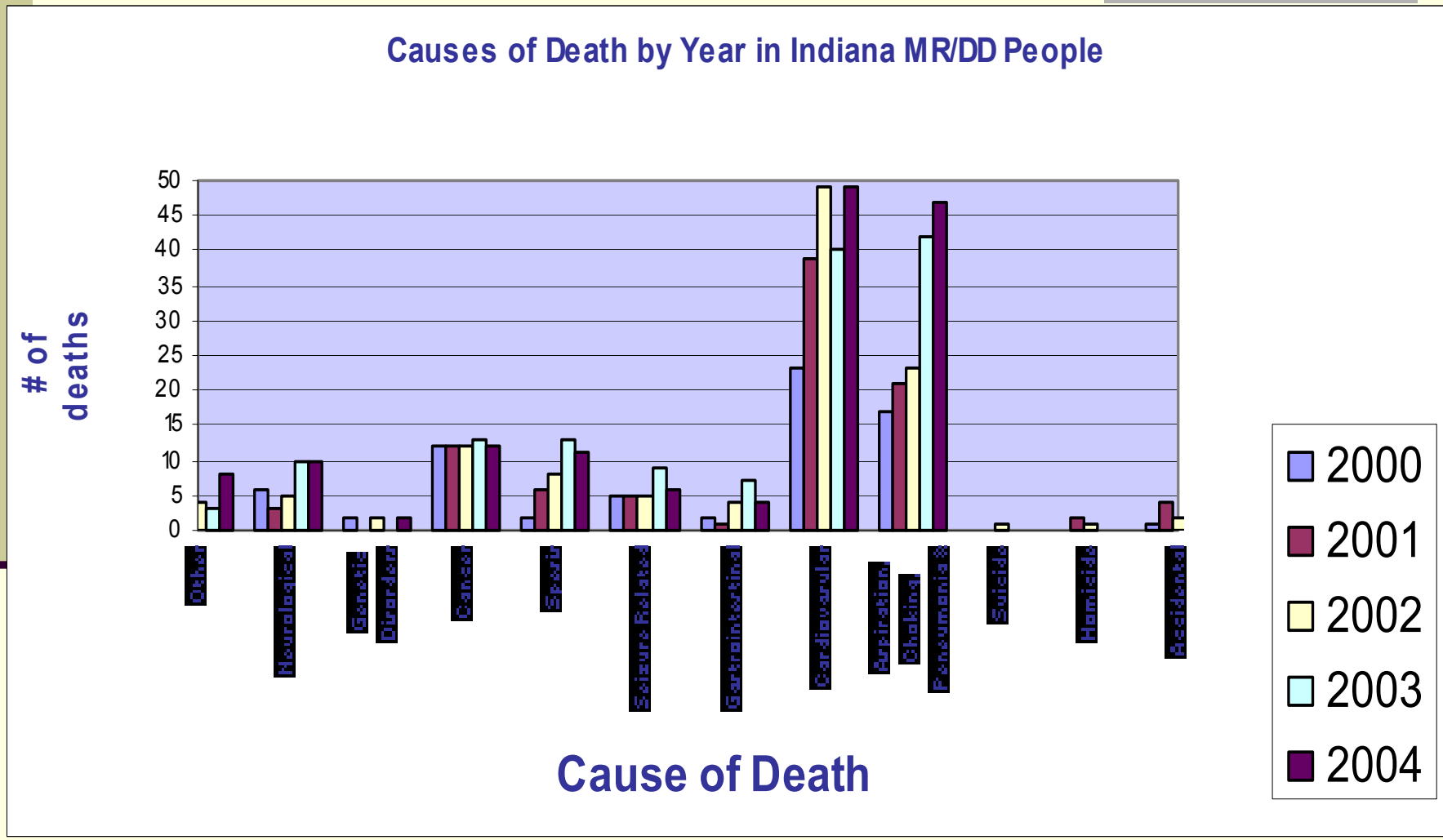
ASPIRATION AND SILENT ASPIRATION

- **ASPIRATION** - passage of food or liquid through the vocal folds and into the lungs
- **SILENT ASPIRATION** - Aspiration occurring with no signs/symptoms (aka triggers)

LONG TERM CONSEQUENCES OF ASPIRATION

- Pneumonia
- Lung Damage
- Death

Cause of Death (MR/DD) in Indiana



ASPIRATION MAY OCCUR ANY TIME DAY OR NIGHT

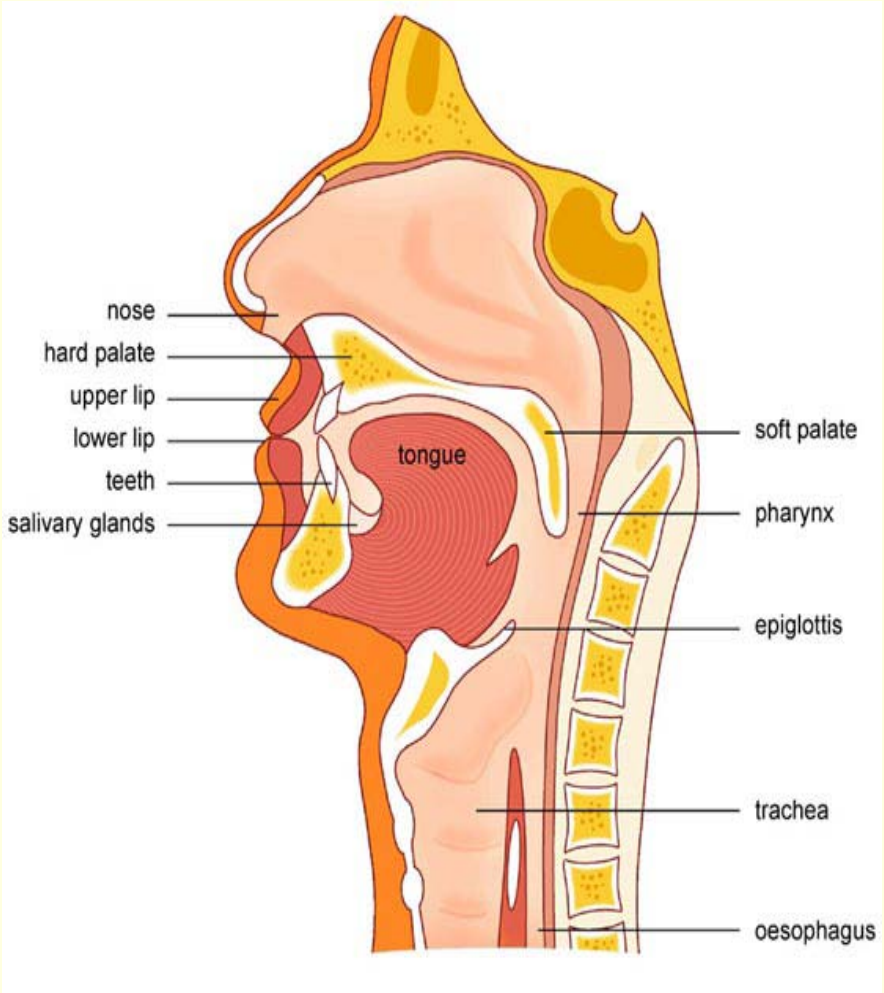
This includes:

- Meals
- Oral Care
- Medication Administration
- Bathing
- Dressing
- Sleeping

DYSPHAGIA

DYSPHAGIA-Difficulty feeding or swallowing

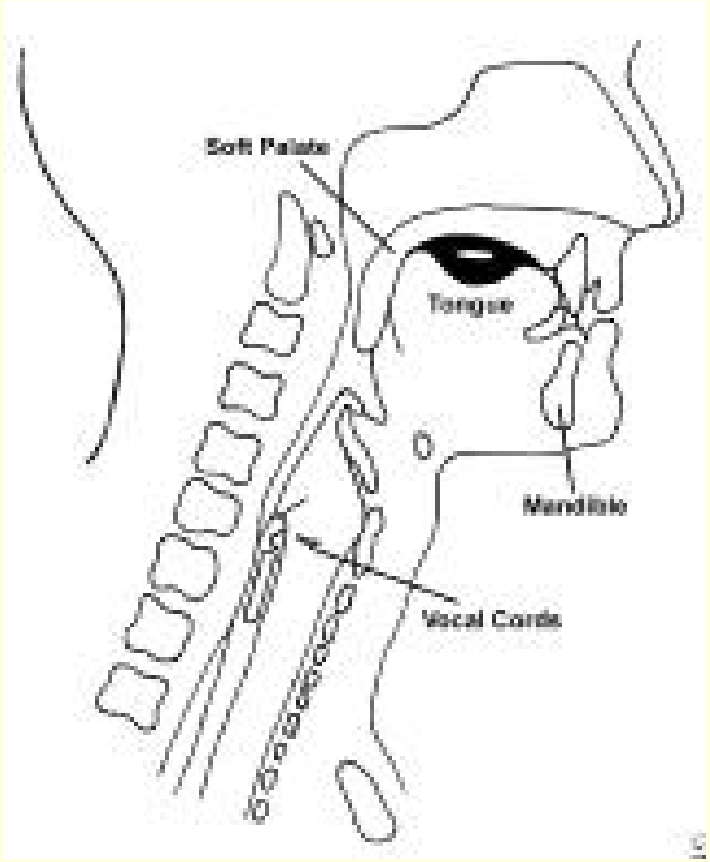
- **3 types of Dysphagia**
  - **Oral**
  - **Pharyngeal**
  - **Esophageal**



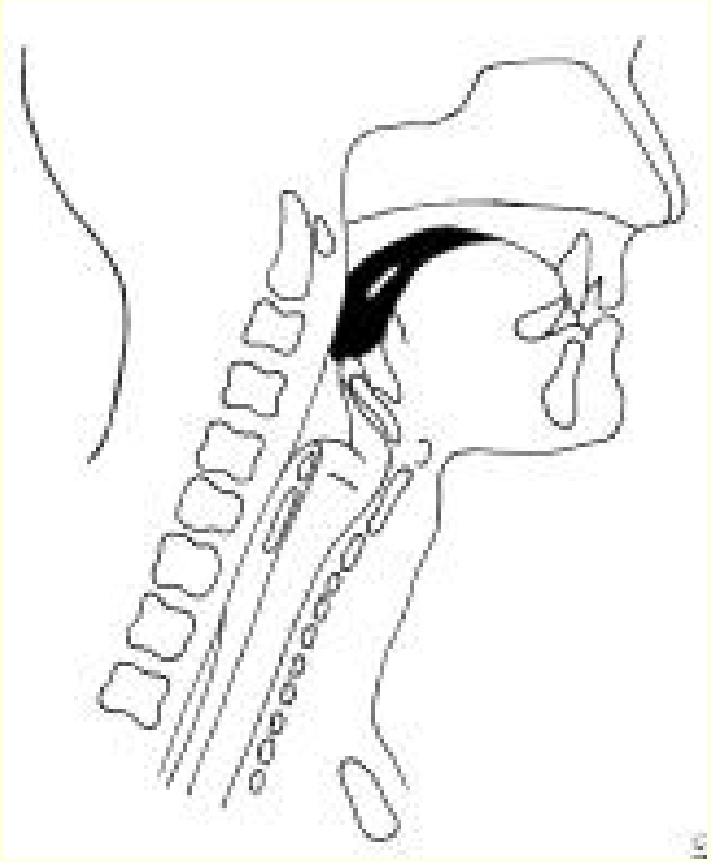
DYSPHAGIA

Swallowing Phases

Oral Prep



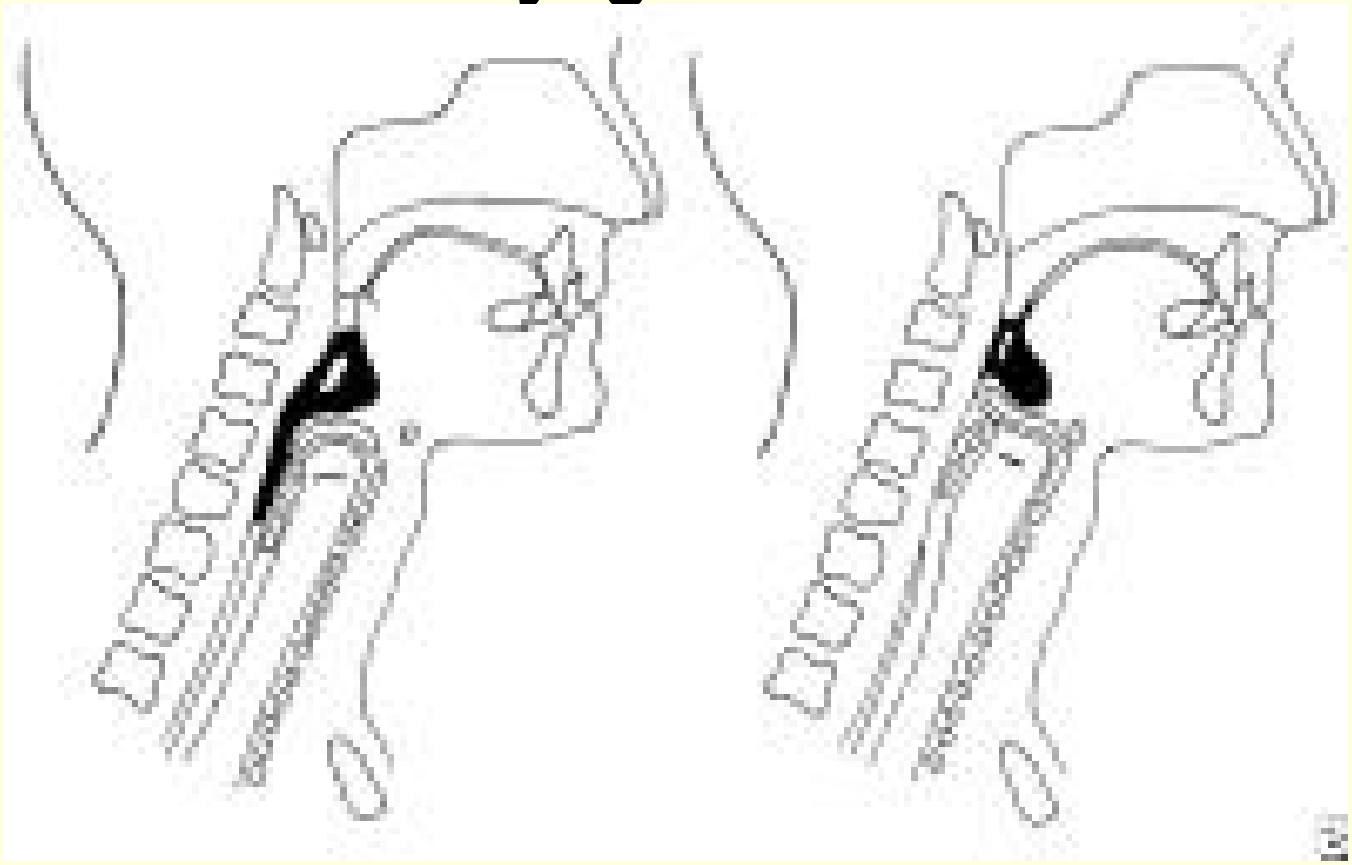
Oral Phase



DYSPHAGIA

Swallowing Phases

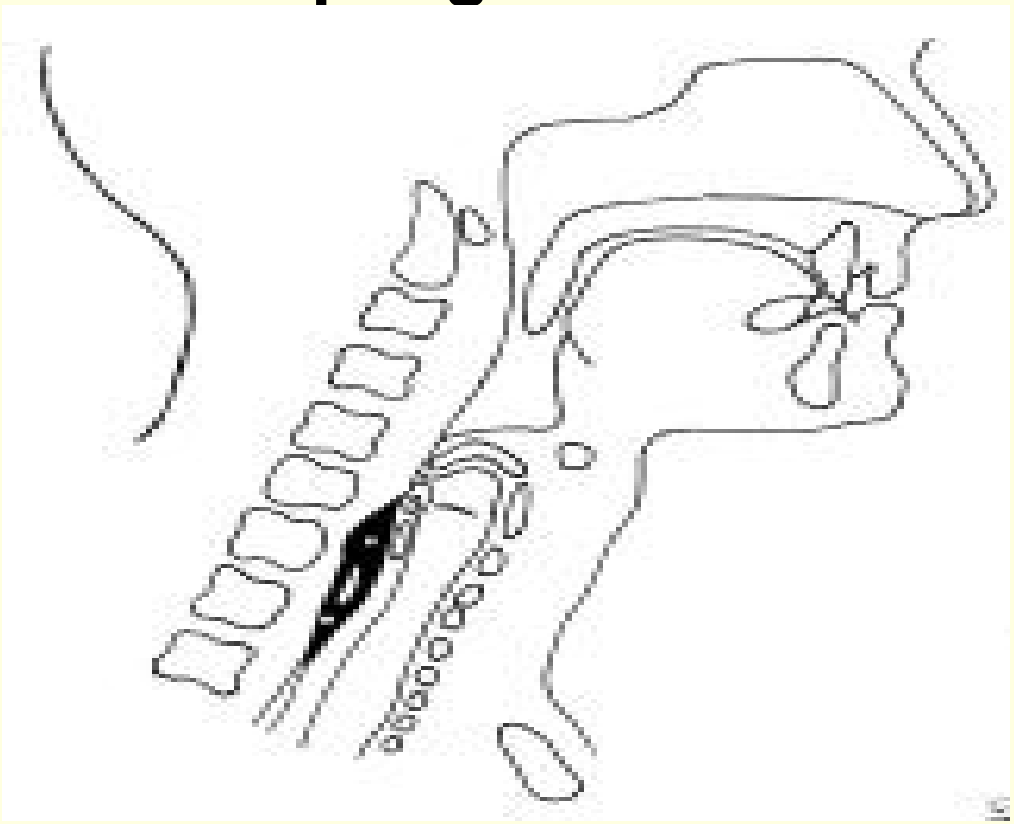
Pharyngeal Phase



DYSPHAGIA

Swallowing Phases

Esophageal Phase



Dysphagia

- **TRIGGERS-** Signs or symptoms associated with possible aspiration

EXAMPLES OF DYSPHAGIA WARNING SIGNS OR TRIGGERS

- Coughing w/ signs of struggle
- Wheezing
- Wet Vocal Quality or Respirations
- Excessive Drooling
- Pocketing of food in the mouth
- Sudden change of color around the lips and face
- Fever (24-48 hours post suspected incident)
- Refusal of foods or liquids
- Watering eyes
- Gagging
- Facial Grimacing
- Smell of formula on breath
- Increased Residuals

Dysphagia Triggers

TRIGGERS SHOULD BE INDIVIDUALIZED

Examples:

- Vocalizing in a low wet sounding moan
- Residue in the mouth after liquid intake
- Fatigues before meal is completed
- Increased vocalizations during oral intake
- Leaning to the left in chair

Coughing or Choking
What's the difference?

COUGHING

- Airway is not blocked
- Keeps your throat and airway clear
- May be dry or productive

- **If Coughing**:
  Encourage coughing and clear airway

CHOKING

- Airway is blocked
- Medical emergency
- Lack of oxygen to the brain

- **If Choking**:
  Follow the provider's emergency protocol

Dysphagia Triggers

What to do if you notice a Dysphagia trigger

Check all Plans:

- Diet Texture
- Fluid Consistency
- Positioning
- Eating Instructions
- Adaptive Equipment
- Pace of Eating
- Bite or Drink Size
- Other Dysphagia Interventions

- INTERVENE AND SELF CORRECT IF ANY OF THE PLANS OR INSTRUCTIONS WERE NOT FOLLOWED CORRECTLY

Dysphagia Triggers

What to do (cont)

IF INDIVIDUAL HAS STOPPED EXHIBITING THE TRIGGER AND IS SAFE FROM HARM:

- Resume meal or activity

IF INDIVIDUAL DEMONSTRATES THE TRIGGER AGAIN:

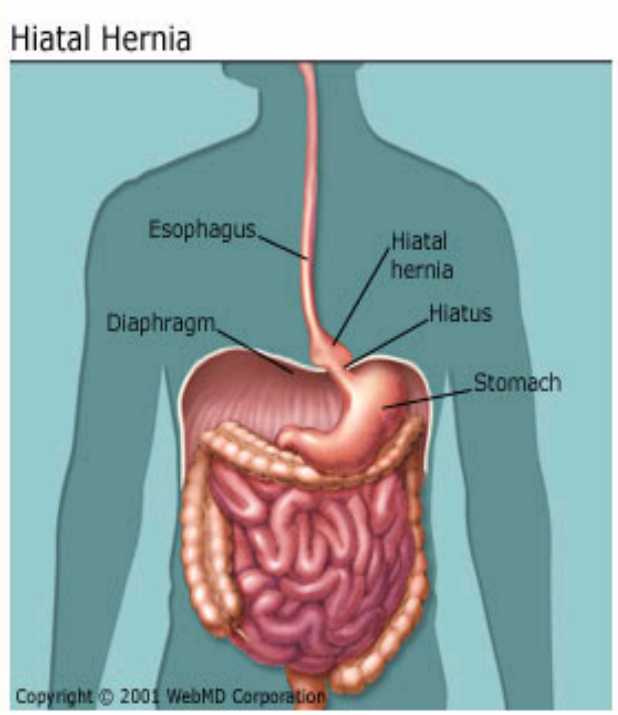
- Stop meal or activity
- Call for an evaluation
- Document who was called and the time of the call
- Document occurrence of trigger on the flow record
- Wait for further instructions

GASTROESOPHAGEAL DISEASE (GERD)

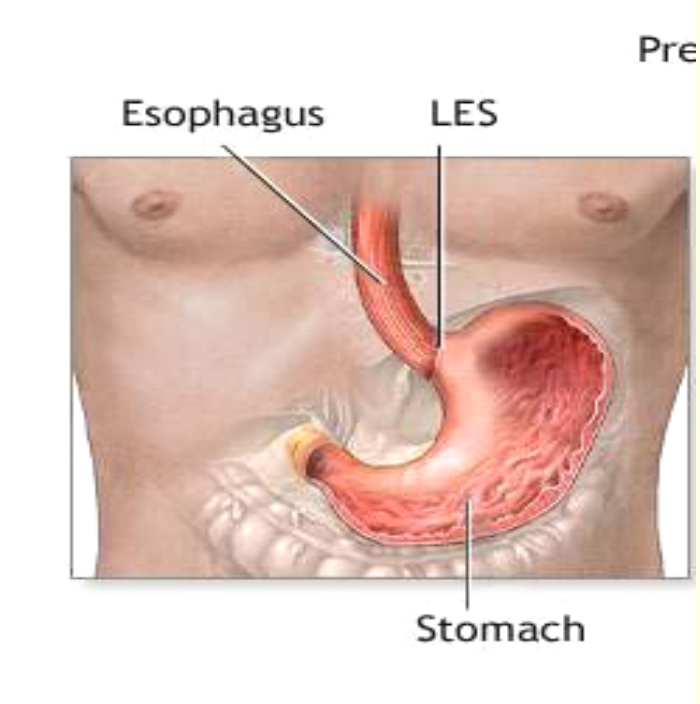
- GERD - Acidic stomach contents that move backward into the esophagus or mouth

CAUSES OF GERD

- **Hiatal Hernia**



- **Lower Esophageal Sphincter Incompetence (LES)**



GERD
Who's at risk?

- People with skeletal deformities
- People who smoke, drink coffee, or alcohol
- People who take relaxants
- People with delayed stomach emptying
- People who eat high fat diets
- People who take medications that relax muscles
- People with seizure disorders that take medication that affects muscle tone

DYSPHAGIA IMPLICATIONS OF GERD

- Inhalation of stomach contents into the lungs (aspiration) resulting in possible pneumonia
- Esophagitis
- Strictures
- Ulcerations

GERD SIGNS AND SYMPTOMS

- Hoarseness
- Drooling
- Coughing
- Hand in mouth
- Repeated swallowing
- Frequent respiratory problems (i.e., coughing, wheezing, bronchitis, pneumonia)
- PICA
- “Sour” smelling or “Formula” burps

TREATMENT FOR GERD

- PROTON PUMP INHIBITORS (Nexium, Prilosec, Prevacid are examples)
- Elevation – from top of head to at least hips, if not able to be totally upright
- Supported so not curving sideways or slumping forward
- Elevated right sidelying or prone positioning may assist with stomach emptying and decrease reflux

TREATMENT FOR GERD (cont)

- Slow down eating
- Encourage thorough chewing
- Frequent small meals
- No meals 2-3 hours before lying down

MINIMIZING THE RISK OF ASPIRATION AND MANAGING DYSPHAGIA

I. GENERAL INFORMATION

- Evaluation
- Preventive Measures
  - Diet Texture
  - Mealtime
  - Oral Care
  - Medication
  - ADLs (personal care, dressing, bathing, toileting, and bedtime)
  - Positioning
  - Training
  - Monitoring and Tracking

II. Program Implementation

EVALUATION

Physician and Nursing >>>	Overall Health and Risk Assessment
Speech Pathologist>>>>>>	Diet Texture and Swallow Evaluation
Occupational Therapist>>>	Adaptive Equipment, Positioning
Physical Therapist>>>>>>>	Positioning, Transfers
Dietary>>>>>>>>>>>>>>>>	Meal and Nutritional Planning
Behavior Clinician>>>>>>>	Behavioral Food Issues

EVALUATION

TEAM APPROACH

- Identify factors that increase the risk of aspiration
- Discuss:
  - Mealtime problems
  - Positioning issues
  - Oral care
  - Medication administration
  - Risk issues

PREVENTITIVE MEASURES
DIET TEXTURE

- Our job is not to take variety away from individual but to ensure that people can safely eat a variety of foods.

- Diet Textures are typically described as:
  - Regular
  - Mechanical #1-Whole Sandwich Meat
  - Mechanical #1-Chopped
  - Mechanical #2 Soft-Ground
  - Pureed

PREVENTITIVE MEASURES
DIET TEXTURE

REGULAR

- This diet includes all foods with no texture restrictions.
- Peanut butter may be thinned with Syrup, Honey, or Jelly

PREVENTITIVE MEASURES

DIET TEXTURE

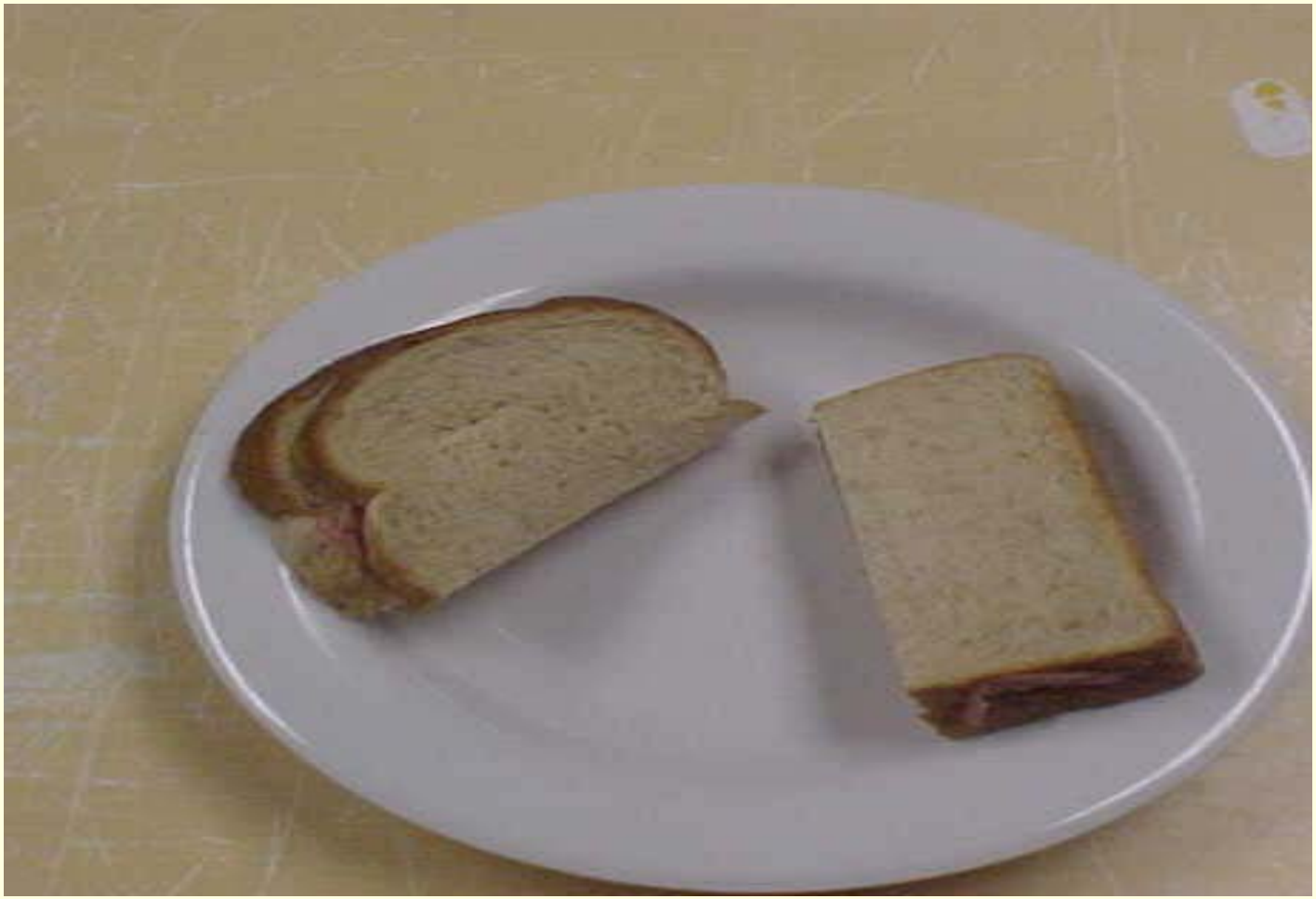
Regular

PREVENTITIVE MEASURES
DIET TEXTURE

MECHANICAL #1-Whole Sandwich Meat

- For individuals who have mild chewing and swallowing deficits. They have increased difficulty tolerating certain types of meats, fresh fruit, and raw vegetables, however they are able to tolerate specific sandwich items.

PREVENTITIVE MEASURES
DIET TEXTURE
Mech #1 – Whole Sandwich Meat



PREVENTITIVE MEASURES
DIET TEXTURE

MECHANICAL (#1)-chopped meat

- For individuals who have mild chewing and swallowing deficits. They have increased difficulty tolerating certain types of meats, fresh fruit, and raw vegetables. These individuals are unable to tolerate whole sandwich items.

PREVENTITIVE MEASURES
DIET TEXTURE
Mech #1 (Chopped meat)

PREVENTITIVE MEASURES
DIET TEXTURE

MECHANICAL (#2) SOFT-ground meat

- For individuals who have limited chewing or swallowing mobility but are able to tolerate a greater variety and texture of foods than the pureed diet offers.

PREVENTITIVE MEASURES
DIET TEXTURE
Mech #2 Soft (Ground Meat)

PREVENTITIVE MEASURES
DIET TEXTURE

PUREED

- For individuals who have severe difficulty chewing or swallowing. All foods are pureed/blended.

PREVENTITIVE MEASURES
DIET TEXTURE
Pureed

PREVENTITIVE MEASURES
DIET TEXTURE

- Drink (Fluid) textures are generally described as:
  - **Thin**-any fluid texture is allowed
  - **Nectar**-tomato juice, prune juice, buttermilk
  - **Honey**-honey, milkshake
  - **Pudding**-spoon thick

PREVENTITIVE MEASURES
DIET TEXTURE (Nectar)

PREVENTITIVE MEASURES
DIET TEXTURE

RESTAURANT FOODS CONSISTENCY CHART

- **All foods whether at the individual's home or away on trips must be modified to fit their specific diet texture.**

- **How to modify foods outside of the home**
  - **Portable Chopper**
  - **Fork mashing**
  - **Cutting with knife**

Restaurant Foods Consistency Chart

- Please refer to your handout.

PREVENTITIVE MEASURES
DIET TEXTURE

Things to Consider:

- The risk for malnutrition and dehydration increases when diet is altered.
- Formal Nutritional Assessment should be completed by a Dietician
- Alternative Nutritional Considerations
  - Airway is repeatedly assaulted regardless of supportive interventions
  - Nutritionally compromised
  - Impairments consistently interfere with food/fluid intake
  - Respiratory Status is compromised

PREVENTITIVE MEASURES
MEALTIME

GENERAL FACTORS

- Dining room should be quiet
- Minimal distractions
- Conversations should not be encouraged when individual has food in their mouth
- Encourage individual to focus on swallowing
- Positioned appropriately
- Monitor food textures

PREVENTITIVE MEASURES
MEALTIME

GENERAL FACTORS cont…

- Straw decreases the level of oral sensation
- Small amounts per bite and sip is easier to manipulate and tolerate
- Alternating sips and bites helps clear the oral cavity
- If wearing dentures, they should be well-fitted
- Remain upright for at least 30-60 minutes after oral intake

PREVENTITIVE MEASURES
MEALTIME

Things to Consider:

- The person may not be able to tolerate 3 large meals
- Liquids that are thickened may change in consistency over time
- Repositioning may be needed during the course of a meal
- Person may fatigue through the meal and have more trouble swallowing safely
- The type of Adaptive equipment needed changes over time
- Swallow strategies change over time

PREVENTITIVE MEASURES
MEALTIME

Positioning

- Make sure the person is properly elevated, aligned and supported.
- Head is maintained in midline with chin tucked unless otherwise specified

Tools

- Adaptive mealtime equipment (coated spoon, divided plate, small bowled spoon, measured cups etc.)
- Adapted positioning equipment
- Compensatory strategies
- Diet texture modifications
- Environmental modifications

PREVENTITIVE MEASURES
MEALTIME

Common Errors

Bites that are TOO BIG and sips that are TOO MUCH

What is too big? Any bite or sip that is unable to be safely handled in 1 swallow

How to Correct

- Follow the dining plan
- Watch the neck for signs of a swallow
- Use the correct utensils
- Do not overload the eating utensil
- Spread food out over entire plate

PREVENTITIVE MEASURES
MEALTIME

Common Errors (cont)

Giving bites and sips *TOO FAST!!!*

What is too fast? When the person does not have time to swallow and breathe between bites or sips.

How to Correct

- Follow the dining plan for the number of swallows needed for each bite or sip
- Know how to identify the person's swallow
- WATCH for the swallow—DO NOT GUESS!
- Watch for distress signals that tell you the person needs to swallow again

PREVENTITIVE MEASURES
MEALTIME

Poor head alignment

What is Poor Head Alignment? When the head is not in midline with a chin tuck (Not only when giving food/fluid but during the swallow).

How to Correct

- Follow the dining plan for instructions on supporting or cueing the person for midline with a chin tuck or as specified.
- A safe practice is maintaining the head in midline with a chin tuck from presentation until after the swallow.

PREVENTITIVE MEASURES
MEALTIME

Poor placement of the food/fluid

What is poor placement? When the food or fluid is placed where the person is unable to safely swallow or handle it.

How to Correct

- Follow the Dining Plan
- Place food/fluid on the center of the tongue or an alternate place in the mouth as noted on the dining plan
- Use the correct utensil as specified on the dining plan.

PREVENTITIVE MEASURES
ORAL CARE

Development of a comprehensive oral care Program significantly:

- Improves quality of life
- Decreases risk of pneumonia

PREVENTITIVE MEASURES
ORAL CARE

Impact of Plaque

Methodology

- 57 ICU patients
- 3 month period assessed for dental plaque

Results

- Increased plaque on the teeth over the time period
- Correlation between dental plaque colonization and microorganism in respiratory secretions
- 21 patients developed pneumonia
- Plaque colonization significantly associated with pneumonia

PREVENTITIVE MEASURES
ORAL CARE

Pneumonias in enterally fed patients is often associated with the aspiration of bacteria from the oropharynx and GI tract.

- Bacteria invade the lower respiratory tract by micro- or bolus aspiration of oropharyngeal organisms

CDC, 1997
Celis, Torres, Gatell, Almela, Rodriguez-Roisin, Agusti-Vidal 1994

PREVENTITIVE MEASURES
ORAL CARE

Chlorohexidine Antispeptic (CHG)

- Study tests CHG effectiveness in oropharyngeal decontamination
- N=353
- Infection rate decreased by 65% in those treated with CHG
- 69% reduction in total respiratory tract infections
- Oropharyngeal rinse was “rigorously” applied to all oral cavity surfaces including the tongue and tooth surfaces
- Example of CHG--Peridex

DeRiso (1996)

PREVENTITIVE MEASURES
ORAL CARE

Cetylpyrdinium Antiseptic (CPC)

- Study tests CPC effectiveness in decreasing oral bacteria
- N=45
- Significant decrease in oral bacteria count
- Example of CPC—Oral-B Anti-Plaque Wash

Kalaga et al, 1989

PREVENTITIVE MEASURES
ORAL CARE

Chlorohexidine

- Kills bacteria on contact
- Prolonged effect after expectoration

Cetylpyrdinium

- Kills bacteria on contact
- Limited abilities after expectoration

PREVENTITIVE MEASURES
ORAL CARE

Oral Care Program

- Tooth brushing x 3 daily (Utilize suction toothbrush for individuals who have difficulty tolerating thin liquids)
- Oral Swab Care x 2 daily with an anti-plaque solution (i.e., Peridex, Oral-B Anti-Plaque Wash)

PREVENTITIVE MEASURES
ORAL CARE

Things to Consider:

- If the person is having difficulty swallowing, or is unable to spit the toothpaste or mouthwash out, then these should be avoided
- Brush one quadrant of teeth, give a short break for person to get a breath and swallow, then brush another quadrant
- A toothette can be used to swab the mouth with diluted mouthwash or diluted toothpaste
- MAKE SURE THE EXCESS WATER, MOUTHWASH, OR TOOTHPASTE IS SQUEEZED OUT

PREVENTITIVE MEASURES
ORAL CARE

- Remember that the individual is required to swallow during tooth brushing.

Positioning

- Make sure the person is properly elevated, aligned and supported
- Head is maintained in midline with a chin tuck

Tools

- Suctioning toothbrush may be helpful
- Collis-Curve toothbrush
- Toothette with fluoride wash

PREVENTITIVE MEASURES
ORAL CARE

Important to view oral hygiene as a priority and not just a comfort measure.

PREVENTITIVE MEASURES
ORAL CARE RISKS

- The technique of brushing the teeth can damage the gums and cause bleeding
- There is the potential that during the process of oral care cleaning that debris may be loosened that can be aspirated into the lower airways.

PREVENTITIVE MEASURES
MEDICATION ADMINSTRATION

Things to Consider:

- The size pill an individual can swallow is the same as their diet texture.
- The consistency of the medication may need to be altered so it can be swallowed safely.
- Runny liquids may need to be altered, and dry medications may need to be added to moist foods so the person can safely swallow it.
- Administration of the medication should be the same as the dining plan, using the same placement techniques, size of presentations, number of swallows etc.
- Utensils must be the same unless otherwise noted on the dysphagia plan.

PREVENTITIVE MEASURES
MEDICATION ADMINSTRATION

- Remember that the person is required to swallow during medication administration

Positioning

- Make sure the person is properly elevated, aligned and supported
- Head is maintained in midline with a chin tuck
- There is a direct relationship between the dining plan and safe medication administration

Tools

- Pill crusher
- Adapted meal equipment

PREVENTITIVE MEASURES

ADLs

Things to Consider:

- The person may benefit from being elevated at all times when being changed, bathed or in bed.
- Lying flat during personal care or dressing increases the risk of reflux aspiration.
- If a person is unable to tolerate thin liquids, care should be taken to ensure that water is not swallowed during baths or showers.

PREVENTITIVE MEASURES

ADLs

- Remember that the risk of aspiration is not limited to mealtime

Positioning

- Make sure the person's positioning program addresses dysphagia and GERD by specifying the position for dressing, toileting, personal care, bathing/showering and bedtime.

Tools

- Wedge
- Hospital bed or elevated bed with bed blocks
- Shower trolley
- Tilt in Space commode/shower chair

PREVENTITIVE MEASURES
POSITIONING

Things to Consider:

All activities require specific position methods

- Toileting and undergarment changes
- Dressing
- Oral care
- Medication administration
- Bathing or showering
- Sleeping
- Eating, swallowing, drinking including those using G-tube
- Stomach emptying
- Bowel and bladder elimination

PREVENTITIVE MEASURES
POSITIONING

Things to Consider (continued):

Variety of positions include

- Wheelchair or other mobility device
- Left sidelying
- Right sidelying
- Prone on forearms or quadruped
- Supine
- Standing or kneeling

PREVENTITIVE MEASURES
POSITIONING

Things to Consider (continued):

The best position for eating, oral care and swallowing…….

- May NOT be sitting up
- Elevated right sidelying or elevated prone
  - ✓ May be a better position for safe swallowing and airway protection
  - ✓ May be a better stomach emptying position
  - ✓ May encourage better abdominal compression to address lower GI problems such as constipation

PREVENTITIVE MEASURES
POSITIONING

Things to Consider:

If the lower GI tract is not working well, is constipated or has poor motility, then the upper part of the GI system will also not be able to work very well.

PREVENTITIVE MEASURES
POSITIONING

Things to Consider:

- Positioning for constipation can include prone on elbows or quadruped and elevated left sidelying.
- Positioning for stomach emptying to decrease reflux can include prone on elbows or quadruped and elevated right sidelying.

PREVENTITIVE MEASURES
POSITIONING

Head Position

- At midline
- Neutral or chin tucked
- 4 fingers flat against the nape of the neck

PREVENTITIVE MEASURES
TRAINING

- Competency based training is “best practice”.
- Competency based training can be divided into 2 categories:

- **Category 1:** General or Foundational competency based training

- **Category 2:** Client Specific competency based training

PREVENTITIVE MEASURES
TRAINING

- This training is General or Foundational training.

PREVENTITIVE MEASURES
TRAINING

- Client specific competency based training regarding dysphagia is in the correct implementation of the client's plans and programs.
- The trainer should visually observe the staff performing the correct techniques outlined in the individual's program.

PREVENTITIVE MEASURES
MONITORING AND TRACKING

Monitoring

- It is “best practice” to monitor an individual’s dysphagia triggers 24/7
- Provides the caregivers with the information needed to be proactive in minimizing the risks associated with dysphagia

Tracking

- Provides information on whether or not the Dysphagia plan is protecting the individual from harm.
- Provides data regarding the severity and # of dysphagia related occurrences.

PROGRAM IMPLEMENTATION

- Interdisciplinary Approach
- Risk Assessment
- Evaluation and Follow-Up
- Intervention
- Monitoring
- Tracking
- Training

Interdisciplinary Approach to Risk Management

- What are the observable and measurable things that are risks and concerns?
- What would you like to see related to this problem?
- What are the suspected causes?

Interdisciplinary Approach to Risk Management

- What intervention are you going to try first and why?
- What information do you need to show that the person is improving or getting worse?
- Who will look at the gathered information, how often will it be looked at, how will the team be notified, and under what circumstances will the plan be reviewed by the team?

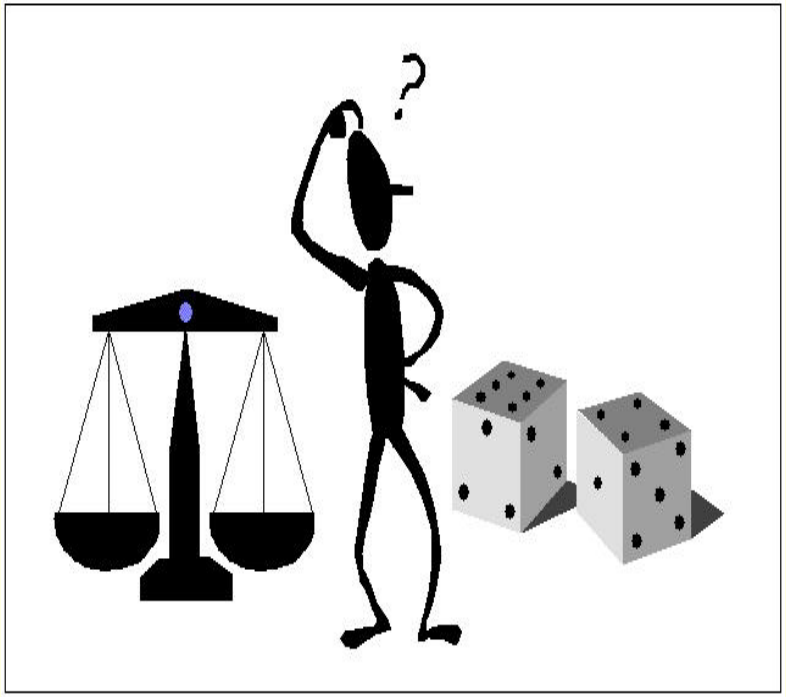
Staying Connected To Your Team

- One to One
- Group Meeting
- Phone
- Voicemail
- E-mail

PROGRAM IMPLEMENTATION
RISK ASSESSMENT

Risk Assessment

- General Risk Factors Assessment
  - Risk Assessment for Choking for Individuals who eat by mouth
  - Assessment of Pneumonia Risk
  - Skin Assessment Tool
  - Braden Scale for Predicting Pressure Sore Risk
  - Mobility Screenings for Persons with Visual Impairments



PROGRAM IMPLEMENTATION
RISK ASSESSMENT

General Risk Factors Assessment

Purpose:

- To identify the individual's level of risk in 5 identified areas (Behavior, Health, Dysphagia, Safety, and Physical Management)
- All checked items should be discussed by the Interdisciplinary Team (IDT) and a corresponding Risk Plan developed

PROGRAM IMPLEMENTATION
RISK ASSESSMENT

Risk Plan should include:

- Interventions to be provided
- Monitoring and Tracking mechanism
- Staff trained
- Implementation of the plan as part of the Individual Support Plan (ISP)

Completed:

- Annually and Reviewed Quarterly by members of the IDT

- ***If selected items are checked in the Dysphagia or Physical Management section, additional risk assessment forms are to be completed and sent to Outreach***

PROGRAM IMPLEMENTATION
RISK ASSESSMENT

ADDITIONAL RISK FORMS:

- **RISK ASSESSMENT FOR CHOKING FOR PERSONS WHO EAT BY MOUTH**
  - Completed by IDT
- **ASSESSMENT OF PNEUMONIA RISK**
  - Completed by IDT
- **SKIN ASSESSMENT TOOL**
  - Completed by IDT
- **BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK**
  - Completed by IDT
- **MOBILITY SCREENINGS FOR PERSONS WITH VISUAL**
  - Completed by IDT

PROGRAM IMPLEMENTATION
RISK ASSESSMENT

- **Choking and Pneumonia Assessment-**must be completed at least annually or as determined by General Risk Factors Assessment

- **Skin and Pressure Sore Assessments-** must be completed at least annually or as determined by General Risk Factors Assessment

- **Mobility Screenings for Persons with Visual Impairments**-must be completed at least annually or as determined by General Risk Factors Assessment

- **Completed originals are to remain on site and a copy mailed or faxed to Southeastern Indiana Outreach Services**

PROGRAM IMPLEMENTATION
RISK ASSESSMENT

Identifying the Individual's Dysphagia Risk Level:

- Dysphagia Risk Level is assigned by Indiana Outreach.
- Risk level is assessed upon completion of the choking and pneumonia assessment forms by provider and receipt of these forms at Outreach.

PROGRAM IMPLEMENTATION
RISK ASSESSMENT

DYSPHAGIA RISK LEVELS

LEVEL 1

- Residents enterally fed
- Residents with a risk of Aspiration as determined by MBS
- Residents with a history of Aspiration Pneumonia
- Residents with Asthma
- Residents with a risk score of 70 or greater as determined by the Choking Assessment Form
- Residents with a risk score of 70 or greater as determined by the Pneumonia Risk Assessment Form

PROGRAM IMPLEMENTATION
RISK ASSESSMENT

DYSPHAGIA RISK LEVELS

LEVEL 2

- Residents with a risk score of 50-60% as determined by the Choking Assessment Form
- Residents with a risk score of 50-60% as determined by the Pneumonia Risk Assessment Form
- Residents with pharyngeal and esophageal phase dysphagia

PROGRAM IMPLEMENTATION

RISK ASSESSMENT

DYSPHAGIA RISK LEVELS

LEVEL 3

- Residents with a risk score of 30-40% as determined by the Choking Assessment Form
- Residents with a risk score of 30-40% as determined by the Pneumonia Risk Assessment Form
- Residents with oral phase dysphagia, GERD, hiatal hernia, reflux, rumination, erosive esophagitis or gastritis.

PROGRAM IMPLEMENTATION
RISK ASSESSMENT

DYSPHAGIA RISK LEVELS

LEVEL 4

- All other residents
- This level has no diagnosis of dysphagia, GERD, or choking risk.

PROGRAM IMPLEMENTATION
EVALUATION AND FOLLOW UP

Evaluation and Follow-Up

- Dysphagia Evaluation
- Positioning Evaluation
- Nutritional Evaluation

PROGRAM IMPLEMENTATION
EVALUATION AND FOLLOW UP

DYSPHAGIA EVALUATION

- Completed by a Speech Language Pathologist with expertise in the area of swallowing and the ID population
- Evaluations and reviews are based on individual's dysphagia risk level.
    - **Level 1**-Annual Evaluation, Monthly Review, and PRN
    - **Level 2**-Annual Evaluation, Quarterly Review and PRN
    - **Level 3**-Annual Evaluation, 6 Month Review and PRN
    - **Level 4**-Annual Evaluation and PRN

PROGRAM IMPLEMENTATION
EVALUATION AND FOLLOW UP

DYSPHAGIA EVALUATION (cont)

- If there is a significant change, a review should be completed immediately
  - visit to ER,
  - unplanned weight loss of 10% in 6 months or more than 5 pounds in one month
  - change in daily schedule
  - any lab work indicating nutritional deficits or dehydration
  - observation of dysphagia triggers
- Dining Plan updates, Dysphagia Plan updates, and Trigger Responses should be completed PRN

PROGRAM IMPLEMENTATION
EVALUATION AND FOLLOW UP

POSITIONING EVALUATION

- Completed by a Therapist with expertise in positioning
- Individual's should be evaluated annually and reviewed quarterly and PRN

PROGRAM IMPLEMENTATION
EVALUATION AND FOLLOW UP

POSITIONING EVALUATION (cont)

- If there is a significant change, individual and positioning program should be reviewed immediately
  - visit to ER
  - unplanned weight loss of 10% in 6 months or more than 5 pounds in one month
  - any existing pressure area that worsens, any pressure area discovered
  - any change to positioning program or equipment
  - change in daily schedule
  - any lab work indicating nutritional deficits or dehydration

PROGRAM IMPLEMENTATION
EVALUATION AND FOLLOW UP

NUTRITIONAL EVALUATION

- Completed by a Dietician
- Individuals are evaluated as needed (i.e., BMI under 18 or over 30)

PROGRAM IMPLEMENTATION
EVALUATION AND FOLLOW UP

NUTRITIONAL EVALUATION

- If there is a significant change, individual should be reviewed immediately
  - unplanned weight loss of 10% in 6 months or more than 5 pounds in one month
  - BMI (Body Mass Index) under 18
  - BMI (Body Mass Index) greater than 30
  - any lab work indicating nutritional deficits or dehydration

PROGRAM IMPLEMENTATION
INTERVENTION

Intervention

- Dining Plans
- Dysphagia Plans
- Positioning Programs
- Dysphagia Triggers Process

PROGRAM IMPLEMENTATION
INTERVENTION

DINING PLANS

- What is a Dining Plan?
- Who needs one?
- Development of the plan
- Use of the plan
- Review and Revision

PROGRAM IMPLEMENTATION
INTERVENTION

DINING PLANS

- **What is it?**
  - A dining plan provides staff with vital information regarding the individual's mealtime structure
    - Risk factors
    - Food and Fluid texture
    - Diet considerations (MD ordered)
    - Behavioral precautions
    - Eating and Drinking strategies
    - Specific mealtime goals
    - Communication strategies
    - Dysphagia triggers
    - Adaptive equipment
    - Eating position
    - Position of staff assisting

PROGRAM IMPLEMENTATION
INTERVENTION

DINING PLANS

- Who needs one?
  - All individuals who are determined to have difficulties during mealtime
    - Behaviors
    - Dysphagia
    - Modified texture
    - Special diets
    - Positioning issues
    - Adaptive equipment

PROGRAM IMPLEMENTATION
INTERVENTION

DINING PLANS

- **Development of the plan**
  - Developed by Speech Pathologist with input and assistance from members of the IDT with knowledge of swallowing disorders and who have attended the Comprehensive Dysphagia Training Program or have been trained by someone who has attended the Training Program (Nurse, OT, PT, RD, and Direct Care Staff)
  - Should identify key mealtime information
  - Should include pictures of adaptive equipment and position during eating
  - Individualized
  - Team approach

PROGRAM IMPLEMENTATION
INTERVENTION

DINING PLANS-Example

- **ASPIRATION RISK**
  CHOKING RISK

- **Behavioral Precautions – [including special table or environment]:**
  - Occasionally stomps feet and bites fingers when upset
  - will shake head “no” to refuses food/activity;
  - self-stimulatory behavior-able to verbally redirect.

- **FOOD TEXTURE:**
  - Pureed

- **FLUID TEXTURE:**
  - Thick-it to fluids to **Honey** Consistency if gel not available.
  - Gels are preferred method of fluids, however, can tolerate honey-thick liquids. If using honey-thick liquids, offer them in a small Nosey cup
  - If using pudding or gel thickness, offer them in a coated spoon

PROGRAM IMPLEMENTATION
INTERVENTION

Dining Plans-Example (cont)

- **CALORIE RESTRICTION:** 1200 low cholesterol

- **SUPPLEMENTS:**
  - Applesauce and bran at breakfast
  - Prunes every meal [no other fruit or desert]

- **EATING:**
  - Requires total set-up and assistance for meals.
  - Wears neck napkin
  - Staff should be seated at eye-level
  - Present food at level of lips and say “take a bite”. Once he takes a bite say “good bite”.

PROGRAM IMPLEMENTATION
INTERVENTION

Dining Plan-Example

Eating (cont)

- Ignore negative behavior “head shaking”, reward positive behavior “taking a bite”.
- Has a tendency to bite the spoon.
- Apply gentle downward pressure on the tongue with the bowl of the spoon during each bite to reduce biting.
- If he tilts head backward during meal, staff should reposition his head, and check to assure mouth is cleared prior to offering more food. Respect his refusal.
- Staff may touch his chin while verbally cueing him to take a bite, however, he **SHOULD NOT** be forced in any way to eat.

PROGRAM IMPLEMENTATION
INTERVENTION

Dining Plan-Example (cont)

- **DRINKING:**
  - No fluids on tray; Gels per memo
  - Gels are preferred method of fluids, however, he can tolerate honey-thick liquids.
  - **DO NOT** discourage coughing

- **SPECIFIC SKILLS TO MAINTAIN/ACQUIRE:**
  - Encourage Choice Making

- **COMMUNICATION:**
  - Vocalizations
  - Facial expressions, behavioral; head shakes yes/no are not always communicative.

PROGRAM IMPLEMENTATION
INTERVENTION

Dining Plan-Example (cont)

TRIGGERS to Notify Nursing Staff:

- Bottom not back in wheelchair
- Coughing with signs of struggle (watery eyes, drooling, facial redness)
- Wet vocal quality
- Vomiting
- Sudden change in breathing
- Watery eyes

DINING PLAN

- **ASPIRATION RISK**
  CHOKING RISK
- **Behavioral Precautions – [including special table or environment]:**
- **FOOD TEXTURE:**
- **FLUID TEXTURE:**
- **CALORIE MODIFICATION:**
- **SUPPLEMENTS:**
- **EATING:**
- **DRINKING:**
- **SPECIFIC SKILLS TO MAINTAIN/ACQUIRE:**
- **COMMUNICATION:**

- **TRIGGERS To Notify Nursing Staff: (These should be individualized)**

- **IF APPROPRIATE EQUIPMENT IS NOT AVAILABLE OR YOU ARE UNSURE OF HOW TO IMPLEMENT THIS PLAN CONTACT YOUR SUPERVISOR**

• Bottom not back in wheelchair • Coughing with signs of struggle (watery eyes, drooling, facial redness) • Wet vocal quality • Vomiting • Sudden change in breathing • Watery eyes	• Total meal refusals (X 2)-nursing notified • Pocketing of food in mouth • Hyper extends neck despite use of compensatory strategies • Weight loss/gain of 5lbs in a month

Dining Plan Outline

- Please refer to the sample Dining Plan provided in your packet

PROGRAM IMPLEMENTATION
INTERVENTION

DINING PLANS

- Use of the Plan
  - Should be available wherever the individual may be eating
  - Dining Plan should be located at tableside for easy reference
  - Staff should refer to the dining plan prior to and during meal.
  - Notify Nurse and/or House Manager if a non-corrected trigger is identified and document on flow sheet or trigger sheet.

PROGRAM IMPLEMENTATION
INTERVENTION

DINING PLANS

- Review and Revision
  - Should be updated as changes occur
  - Review quarterly at IDT meeting or in the occurrence of a significant change (unplanned weight loss or gain , hospitalization, observation of triggers)

PROGRAM IMPLEMENTATION
INTERVENTION

Dysphagia Plans

- What is a Dysphagia Plan?
- Who needs one?
- Development of the plan
- Use of the plan
- Review and Revision

PROGRAM IMPLEMENTATION INTERVENTION

Dysphagia Plans

- What is a Dysphagia Plan?
  - Provides Vital information regarding the individual's physical and nutritional health.
    - Risk areas
    - Dysphagia triggers
    - Nutrition and Mealtime
    - Oral Care and Medication Administration
    - General positioning
  - Covers all areas of the individual's daily life

PROGRAM IMPLEMENTATION INTERVENTION

Dysphagia Plans

- Who needs one?
  - Diagnosis of Oral, Pharyngeal, or Esophageal Dysphagia
  - Diagnosis of GERD, Reflux Esophagitis, History of Pneumonia or Aspiration Pneumonia
  - All individuals who are determined by Outreach to be at a level 1, 2, or 3 dysphagia risk.

PROGRAM IMPLEMENTATION
INTERVENTION

Dysphagia Plans

- **Development of the plan**
  - Developed by Speech Pathologist with input and assistance from members of the IDT with knowledge of swallowing disorders and who have attended the Comprehensive Dysphagia Training Program or have been trained by someone who has attended the Training Program (Nurse, OT, PT, RD, and Direct Care Staff)
  - Should identify key information (diagnoses, triggers, mealtime, oral care and medication administration, & general positioning)
  - Individualized
  - Team approach

AGENCY
DYSPHAGIA CARE PLAN
_____*Client's Name*_____
Date
Level of Risk

_____
_____
_____

Diagnoses related to Dysphagia (i.e., GERD, Oral, Pharyngeal, Esophageal Dysphagia, Aspiration or Choking risk etc…)

TRIGGERS:
In this section you will include specific triggers (aka signs or symptoms) that are related to the individual having increased difficulty swallowing, tolerating tube feedings, tolerating their own secretions or positioning triggers during mealtme)

IF YOU NOTICE ONE OR MORE OF THE ABOVE TRIGGERS, ATTEMPT TO SELF CORRECT (make sure dysphagia plan is being followed correctly)
IF TRIGGER IS OBSERVED AGAIN, DOCUMENT ON FLOW CHART AND NOTIFY NURSE OR House MANAGER.

NUTRITION AND MEALTIME

This section includes information on the client's food textures, fluid textures and supplements. If NPO, this should be listed here as well as the client's rate and frequency of feedings. Any adaptive equipment, positioning information (during and after meals) and dining strategies (small bites, alternating liquids/solids etc…) should be included.

ORAL CARE and MEDICATION ADMINISTRATION

Oral Care Guidelines (suctioning or non-suctioning), positioning, and fluid texture information are included in this section

GENERAL POSITIONING

Positioning as it relates to bathing, attends changes, and showering are included in this section. ***Remember*** *that an individual should be positioned in an upright manner when performing these activities.* ***Refer to Positioning Plan for specifics.***

Quarterly Review:

1st Quarter	2nd Quarter	3rd Quarter

Dysphagia Care Plan

- Please refer to the handout

PROGRAM IMPLEMENTATION INTERVENTION

Dysphagia Plans

- Use of the plan
  - Plan should be located in a place that is easily accessible to all staff.
  - Staff should refer to the Dysphagia Plan prior to participating in any identified areas addressed by the plan (oral care, medication administration etc..)
  - Notify Nurse and/or House Manager if a non-corrected trigger is identified and document on flow sheet or trigger sheet

PROGRAM IMPLEMENTATION INTERVENTION

Dysphagia Plans

- Review and Revision
  - Should be updated as changes occur
  - Review quarterly and annually at IDT or in the occurrence of a significant change (unplanned weight loss or gain , hospitalization, observation of triggers)
  - Review Date and Reviewer should be documented in Grid on Care Plan

PROGRAM IMPLEMENTATION INTERVENTION

Positioning Programs

- What is a Positioning Program?
- Who needs one?
- Development of the program
- Use of the program
- Review and Revision

PROGRAM IMPLEMENTATION
INTERVENTION

Positioning Programs

- What is a Positioning Program?
  - Includes optimal positions for:
    - Eating and Swallowing
    - Medication Administration
    - Stomach Emptying
    - Bowel and Bladder Elimination
    - Oral Care
    - ADLs (personal care, dressing, bathing/showering)

PROGRAM IMPLEMENTATION INTERVENTION

Positioning Programs

- **Who needs one?**
  - Person who is unable to move themselves INDEPENDENTLY into or out of a variety of positions throughout a 24 hr day
  - Person who spends >2 hrs out of a 24 hr day in a wheelchair
  - Person who spends > 12 hrs out of a 24 hr day in a recumbent position (time in bed, recliner, lying down on mat etc..)
  - Person who has a Braden scale of 18 or lower
  - History of any skin breakdown related to: pressure, poor nutrition or hydration, shear or friction, moisture, contractures or poorly fitting equipment with the last 3 yrs.

PROGRAM IMPLEMENTATION
INTERVENTION

Positioning Programs

- **Who needs one? (cont)**
  - Unable to sit upright for any reason
  - Requires support of head, trunk, upper or lower extremities to maintain an upright or near upright position
  - Demonstrates obligatory primitive postural, obligatory movement reflexes or unmanageable postural tone such as extensor tone in supine position
  - Demonstrates postural or skeletal deformities related to an inability to resist forces of gravity such as scoliosis, kyphosis, windswept or frog leg pelvic deformity.
  - Requires adapted supportive or positioning equipment to complete ADLs
  - Person who has 2 or less positions they can tolerate
  - Diagnosis of GERD, Reflux Esophagitis, History of pneumonia or Aspiration Pneumonia, and Asthma

PROGRAM IMPLEMENTATION INTERVENTION

Positioning Programs

- **Development of the program**
  - Developed by an Occupational or Physical Therapist with input and assistance from other members of the IDT (Nurse, SLP, RD, and Direct Care Staff)
  - Should include specific positioning methods (written and photographed)
    - Bathing/Showering
    - Toileting and Personal Care
    - Dressing
    - Oral Care and Medication Administration
    - Degree of elevation for each position

PROGRAM IMPLEMENTATION INTERVENTION

Positioning Programs

- Use of the Program
  - Program should be located in a place that is easily accessible to all staff.
  - Staff should refer to the Positioning Program prior to participating in any identified areas addressed by the plan (i.e., oral care, medication administration etc..)

PROGRAM IMPLEMENTATION INTERVENTION

Positioning Programs

- Review and Revision
  - Should be updated as changes occur
  - Review quarterly at IDT or in the occurrence of a significant change (unplanned weight loss or gain , worsening or discovery of a pressure area, hospitalization, observation of triggers etc..)
  - Review should be documented and dated using the review grid at the bottom of each position intervention

PROGRAM IMPLEMENTATION
INTERVENTION

Dysphagia Trigger Process

1. It is “best practice” that all clients living in the community setting with the diagnosis of Dysphagia have a Dysphagia Care Plan (DCP)
2. **All clients** should have a Dining Plan
3. Direct Support Staff ensures proper implementation of Plan (positioning, diet texture, etc.).
4. Direct Support Staff identifies that triggers has occurred and immediately assist
5. If triggers occur and plan is not being followed, follow plan and notice if triggers continue.

PROGRAM IMPLEMENTATION
INTERVENTION

Dysphagia Trigger Process (cont)

6. If triggers continue, stop meal or activity, document on flow chart or trigger sheet and notify Nursing and/or House Manager.
7. Person notified should immediately
   - Verify that the Dysphagia Care Plan is being followed
   - If not, ensure proper implementation
   - Checks pulse, respirations, and breath sounds
   - Check O2 sats if there is distress noted or congestion is present
8. Determines if client's health is compromised and is in need of immediate evaluation.

PROGRAM IMPLEMENTATION
INTERVENTION

Dysphagia Trigger Process (cont)

9. If client's health is compromised and is in need of immediate evaluation, client is sent to ER/Hospital.
10. After assessing the client's status and providing immediate care, Determine if modifications to the plans are temporarily needed to ensure safety and what evaluations are needed.

PROGRAM IMPLEMENTATION
INTERVENTION

Dysphagia Trigger Process (cont)
Recommended Response to Incident

11. It is recommended that the Nurse or House Manager notify the appropriate therapist of client's condition by the next business day.
12. Therapist schedules evaluation upon client's return home from the ER/Hospital within
    - 3 business days for Dysphagia Level 1
    - 5 business days for Dysphagia Level 2
    - 7 business days for Dysphagia Level 3
    - 14 business days for Dysphagia Level 4

- If ER/Hospital visit is not required, Nurse or House Manager notifies the appropriate community therapist (OT, PT, SLP, or RD) the next business day and therapist schedules an in-home evaluation to be conducted within:
  - 3 business days for Dysphagia Level 1
  - 5 business days for Dysphagia Level 2
  - 7 business days for Dysphagia Level 3
  - 14 business days for Dysphagia Level 4

PROGRAM IMPLEMENTATION INTERVENTION

Dysphagia Trigger Process (cont)

Recommended Response to Incident

13. Once the client is evaluated, Therapist from the community should make recommendations and provide follow through within:
    - 3 business days for Dysphagia Level 1
    - 5 business days for Dysphagia Level 2
    - 7 business days for Dysphagia Level 3
    - 14 business days for Dysphagia Level 4

PROGRAM IMPLEMENTATION
INTERVENTION

Dysphagia Trigger Process (cont)

14. An IDT should be held within 5 days of the completed evaluation to discuss the incident and ensure recommendations of all involved disciplines have been implemented and trained.
    - Pneumonia and Choking Assessment will be conducted by members of the IDT and a copy will be sent to the Primary Outreach Team and the level of Dysphagia Risk will be reviewed and Risk Level will be modified as needed.

15. If a client does not currently have a Dysphagia Care Plan and triggers are identified—start at step #6. Dysphagia and other Plans will be developed based on the therapist's review.

PROGRAM IMPLEMENTATION
INTERVENTION

Dysphagia Issues requiring Immediate evaluation (ER/Hospital visit):

- choking
- Decreased pulse or respirations
- coarse or wet breath sounds
- client distress or congestion

Actions:

1. Client is sent to ER/Hospital
2. Nurse or House Manager notifies therapist the next business day
3. Therapist evaluations are provided based on risk schedule upon client's return home.

Dysphagia Issues not requiring immediate evaluation:

- coughing w/ signs of struggle
- wet vocal quality
- excessive drooling
- pocketing of food in mouth
- behavior issues during mealtime (chugging of liquids, large bites)
- facial grimacing
- increased residuals
- refusal of food or fluids x2
- improper positioning

Actions:

1. Nurse or House Manager assesses situation
2. Immediate evaluation (ER) is not needed
3. Temporary modifications are made to plans
4. Nurse or House Manager contacts Therapist the next business day
5. Therapist evaluations are provided based on risk level

Aspiration Protocol (Sample)

- Please refer to your handout at this time.

PROGRAM IMPLEMENTATION MONITORING

- Dysphagia Schedule
- Positioning Schedule
- Monitoring Forms

- It is “best practice” to monitor an individual’s dysphagia triggers and positioning

PROGRAM IMPLEMENTATION MONITORING

Dysphagia Schedule

- Serves as a guide to assist the provider through the monitoring process
- Provides information on the type of monitor and frequency of monitoring sessions
- Frequency of monitors are based on the individual's dysphagia risk level
- Covers all areas where the individual is determined to be at risk

AGENCY DYSPHAGIA MONITORING SCHEDULE

	Number, Type, and Frequency of Monitoring			
Type of Monitor	**Level 1 2 types per month**	**Level 2 1 type per month**	**Level 3 1 type per quarter**	**Level 4 at ISP Update**
Dental	1/year	1/year	1/year	annual eval
Oral Care	4/year	1/year		annual eval
Bathing	3/year	1/year	1/year	annual eval
Dressing	4/year	1/year		annual eval
Documentation Review	1/quarter	1/quarter	1/6 months	annual eval
Med-Pass	2 a.m./year 2 p.m./year	1/year	1/year	annual eval
Mealtime/Snack	8/year	6/year	1/year	annual eval
Total Doc Reviews/year	4	4	2	annual eval
Total Monitors/year	24	12	4	annual eval

PROGRAM IMPLEMENTATION MONITORING

Positioning Schedule

- Name of Client, revision date and individual who revised the schedule
- Beginning and ending time for the position
- Specific position including amount of elevation
- Schedule should cover 24 hrs day
- Data collection for each position
- Staff initials responsible for the positioning program
- Schedule includes position for : Bathing/Showering, Toileting and Personal Care, Oral Care and Medication Administration, and need to be elevated at all times)

PROGRAM IMPLEMENTATION
MONITORING

MONITORING FORMS

- Dysphagia Plan Monitor
- Dysphagia Documentation Review

PROGRAM IMPLEMENTATION
MONITORING

Dysphagia Plan Monitor

- Serves as a general and client specific dysphagia and dysphagia positioning review
- Monitors all areas of the client's day
  - Mealtime
  - med pass
  - Dressing
  - oral care
  - Bathing
  - dental
- Frequency of monitors are based on client's dysphagia risk level.
- Follow dysphagia schedule

- **Should be completed by members of the IDT who have completed Indiana Outreach's Comprehensive Dysphagia Training Program**

Dysphagia Plan Monitor

- Please refer to the sample provided in your packet

Dysphagia Plan Monitor Directions

1. Insert the name of the resident being monitored, location and provider, staff member working with resident and the date and time of the monitor.
2. Place a check in the situation (breakfast, lunch, med pass, changing etc…) being monitored.
3. Answer Yes, No, or N/A to the provided 24 questions.
4. If the answer is “No” to questions 1-14; the monitor must train the individual on the spot and answer “Yes” to question 23.
5. If training was needed, the training section should be filled out by the monitor stating the area and question # that was trained.
6. Observed staff member and monitor must both sign the form verifying that training occurred regarding the observed deficit.
7. In the space “Actions Taken To Address Identified Issues” , Briefly summarize all steps that were taken to address questions 1-14 that were answered “NO”
8. Keep forms on site

PROGRAM IMPLEMENTATION MONITORING

Dysphagia Documentation Review

- Provides structure to the process of reviewing a client's dysphagia plan, monitoring, and tracking processes
- Frequency of documentation reviews is based on the client's dysphagia risk level
- Follow dysphagia schedule

- **Should be completed by members of the IDT who have completed Indiana Outreach's Comprehensive Dysphagia Training Program**

Dysphagia Documentation Review

- Please refer to the sample provided in your packet

Dysphagia Documentation Review Directions

1. Insert the name of the resident being reviewed, the dysphagia plan date, and documents reviewed.

2. Documents reviewed should include the Nursing Flow Chart, Med Sheet, Dietary Notes, Consult Notes and any other documents that provide pertinent medical information.

3. If the answer is “NO” to questions 1-5, a plan should be in place that addresses the issue.

4. Keep forms on site

PROGRAM IMPLEMENTATION TRACKING

Tracking

- Flow Record

Flow Record

- Please refer to the sample provided in your packet

PROGRAM IMPLEMENTATION TRACKING

Flow Record

- Provides a way for staff to document and track dysphagia triggers as well as other pertinent medical information
- Additional information on the “flow record” replaces many existing forms
  - Vitals
  - Meals (I/O)
  - GI
  - Triggers
  - G-Tube
  - Skin
  - Oral Care
- Data can be easily viewed and analyzed

Flow Record Directions

Direct Support Staff

- **Vitals**
  - Record Monthly/Daily on Flow Record
  - Use Vita Sign Record if vital signs are taken more frequently than daily
  - If O2 Sat is taken more than once a day, utilize Progress Notes entry.
- **Meals**
  - For all clients record % of Meals/Snacks eaten and fluid intake
- **GI**
  - Suppository – Y or N
  - Enema – F-Fleets, SS – Soap Suds
  - Chart results in Progress Notes as well as on Flow Record
  - BM

    Utilize Code:

    I – Soft
    II – Hard
    X – Liquid
    M – Medium
    L – Large
    XL – Extra Large
  - Last Void (time)
  - Vomitus – Y for Yes, N for No

Flow Record Directions

Direct Support Staff (cont)

- **Triggers**
  - For each trigger, if it did not occur or was corrected by staff intervention *(**self-corrected***), put a dash (-) in the space.
  - If trigger did occur and intervention did not work (***non-corrected***), mark the number of times it occurred
- **G-Tube**
  - Formula – Identify type of feeding and amount
  - Residual – Amount: if > 25cc, chart a progress note
  - Site Care – Y/N: if redness or drainage present, chart until Resolved (R) with progress note entry

Flow Record Directions

Direct Support Staff (cont)

- **Skin**
  - Abrasion/Scratch – Location (Progress Note Entry)
  - Bruise – Location, R-resolved (Progress Note Entry)
  - Other – Chart location on Flow record and document in Progress Notes if a skin breakdown is noted. Documentation to occur until Resolved (R). For example: if redness is noted, indicate location under Other. Mark R when resolved, (Progress Note Entry)
- **Oral Care**
  - Suction Tooth Brushing – Check mark for completion
  - Oral swab – Check mark for completion
  - Toothbrush – Check mark for completion

Flow Record Directions

Nurse

- Should initial each Flow Record after data is reviewed. Perform appropriate follow-up.

PROGRAM IMPLEMENTATION TRACKING

REMEMBER:

- A "**TRIGGER**" can occur at any time, 24/7
- A "**SELF-CORRECTED TRIGGER**" means that it occurred one time and the intervention you provided was successful in preventing it from happening again
- A "**NON-CORRECTED TRIGGER**" means that the intervention was not successful and the trigger occurred a second time.

- ***A "NON-CORRECTED TRIGGER" must be documented on the flow record and reported to Nurse***

PROGRAM IMPLEMENTATION
TRAINING

- All staff should be provided with Client-Specific Competency Based Training
- **Competency in:**
  - Dysphagia
  - Mealtime
  - Oral Care and Medication Administration
  - Positioning for dressing, bathing, personal care, toileting and sleeping
- **Must be trained and verified**

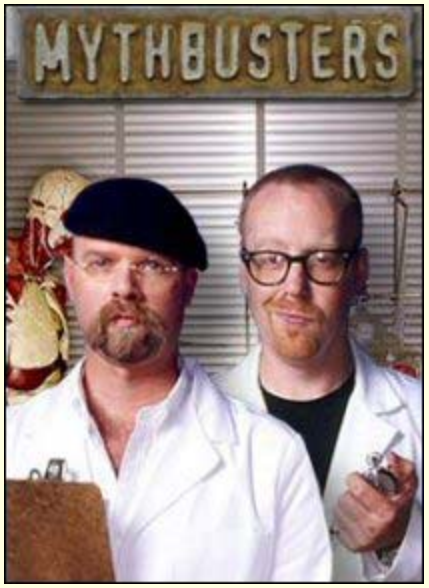
- **Trainers should have completed Indiana Outreach's Comprehensive Dysphagia Training Program**

PROGRAM IMPLEMENTATION
TRAINING

Competency Based Training

- Competency is verified as trained (T), competent (C) or needs further training (N=not correct or requires prompting)

MythBusters
Myth or Fact ?



- It is normal for some people to cough throughout their meal.
- It is a good sign for someone to cough up a lot of phlegm first thing in the morning or after a drink of juice (for example) because they are getting that junk out of their lungs.
- Milk and Milk products should be avoided by people who have swallowing problems because it makes them produce more mucous.
- Even though a person is getting only pureed food, it is okay for them to have chocolate pieces or other foods that “melt in your mouth”.
- If a person is coughing during meals, that means they are okay and are not aspirating.
- If a person is not coughing during meals, that means they are okay and are not aspirating.

MythBusters
Myth or Fact ? (cont)

- A straw is always helpful in providing liquids to an individual, especially if they show signs of oral spillage.
- If a person has dysphagia and is supposed to sit upright when eating but is able to say that they want to lay back in the recliner to eat, that is their right to eat there.
- I like to eat in my bed and recliner so it should be okay for a person with dysphagia to eat in their recliner or bed.
- If nothing bad has happened up until now, it isn't going to happen.

If you are not concerned, maybe even a little nervous about someone's safety at meals, you <u>SHOULD NOT</u> be assisting them.

THINK: Are you willing to bet someone's life on a myth?

KNOW THE FACTS ABOUT DYSPHAGIA

Benefits of Physical and Nutritional Management

- **Dining Plans**
  - Provides staff with the information needed to safely assist individuals with mealtime issues
  - Minimizes the risk of choking
  - Minimizes the risk of aspiration
  - Minimizes the risk of dehydration and malnutrition

- **Dysphagia Plans**
  - Serves as a guideline for staff regarding the individual's physical and nutritional health
  - Provide specific information on risk areas, dysphagia triggers, nutrition and mealtime, oral care and medication administration, and general positioning recommendations

Benefits of Physical and Nutritional Management

- **Positioning Programs**
  - Improves GI, urinary and respiratory functioning
  - Minimizes current and prevents further deformity
  - Improves safety, health and comfort of client
  - Prevents skin breakdown and decubitus
  - Improves client's ability to use functional skills in meaningful activities

- **Dysphagia Trigger Process**
  - Assists in removing the guesswork that staff may face when a trigger occurs
  - Increases the level of awareness
  - Provides a standard of care
  - Increases communication between IDT members

Benefits of Physical and Nutritional Management

- Dysphagia Schedule
  - Covers all areas where the individual is determined to be at risk of aspiration
  - Serves as a guide to assist the provider through the monitoring process
- Dysphagia Plan Monitor
  - Provides a general and client specific dysphagia and dysphagia positioning review
  - Assists in the updating of care plans and identification of dysphagia issues

Benefits of Physical and Nutritional Management

- **Dysphagia Documentation Review**
  - Ensures monitors and tracking are being conducted and triggers are responded to by the appropriate IDT member
- **Flow Record**
  - Provides structure for staff to document and track dysphagia triggers as well as other important information
  - Helps staff become more aware and proactive in the protection of our clients
  - Minimizes risk of aspiration
  - Minimizes risk of choking

Benefits of Physical and Nutritional Management

- Persons with Intellectual Disabilities are healthier and safer
- Deaths are prevented
- Less pain and suffering by clients
- Improved quality of life for clients
- By being proactive, issues will identified before they become problematic
- Fewer non-routine medical visits, emergency room visits, and hospitalizations
- Less staff time spent preparing for and accompanying person on medical visits
- Reduced reactionary interventions by IDT members
- Improved communication and knowledge base of staff and members of the IDT
- Fewer crisis situations
- Fewer incident reports to complete
- Fewer regulatory surveys and monitors following up on crisis situations

In Closing

- Know the Facts
- Protect the Individual
- Assess Risk Areas
- Develop 24/7 Dysphagia Plans
- Develop Dining Plans
- Develop Positioning Plans
- Monitor and Track Triggers
- Implement Competency Based Training

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Websites of Interest

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- www.dysphagiaonline.com
- http://www.aappspa.org
- http://www.gerd.com
- http://www.in.gov/fssa/servicedisabl/seoutreach/index.html

Question #12

Question #13

Question #14

Question #15

Question #16


MARSH
CULTURED REDUCED FAT BUTTERMILK
MARSH
CULTURED REDUCED FAT BUTTERMILK
2% MILKFAT
VITAMIN A & D
JUMEX
Pineapple
Nectar
GOLD
SQUEEZED
JUICE
JUMEX
Guava
Nectar
DEL
Valle
MANGO